STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012688	A. BUILDING: _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANNONI LIVING CENTER, THE	500 LINCOLNWAY EAST MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 1, 2, 2014 Facility number: 012688 Provider number: 012688 AIM number: N/A Survey team: Julie Wagoner, RN, TC Deb Kammeyer, RN Sharon Ewing, RN Lora Swanson, RN Census bed type: Residential: 21 Total: 21 Census payor type: Medicaid: 17 Other: 04 Total: 21 Residential sample: 07 Vannoni Living Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Licensure Survey. Quality Review 10/03/14 by Lisa McColly	R 000		